Appendix 26
American Dental Association Claim Form Example

Dental Claim Form See reverse for instructions

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID # 12345678

2. ☐ Medicaid Claim ☐ EPSDT Prior Authorization # 1234567 Patient ID # 1234567890

3. Carrier name and address

PATIENT COVERAGE INFORMATION

4. Patient name: first Im; m.i. A.; last Recipient

5. Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other

6. Sex: m f — X

7. Patient birthdate: MM DD YYYY — MM DD YY

8. If full time student: school; city 1234JED

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate: MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan: yes no. If yes, complete 15-a. Is patient covered by a medical plan? yes no

15-a. Name and address of carrier(s): M-6 OI-P

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate: MM DD YYYY

18. Relationship to patient: ☐ self ☐ parent ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

› Signed (Patient* – see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

› Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity: IM Billing

22. Address where payment should be remitted: 1 W. Williams

23. City, State, Zip: Anytown, WI 55555

24. Dentist Soc. Sec. or T.I.N. (see reverse**)

25. Dentist license no.

26. Dentist phone no.

30. Is treatment result of occupational illness or injury? No: X Yes:

31. Is treatment result of auto accident? No: X Yes:

32. Other accident? No: X Yes:

If yes, enter brief description and dates

33. If prosthesis, is this initial placement?

(If no, reason for replacement)

34. Date of prior placement

27. First visit date current series

28. Place of treatment: Office Hosp. ECF Other 3

29. Radiographs or models enclosed? No Yes How many?

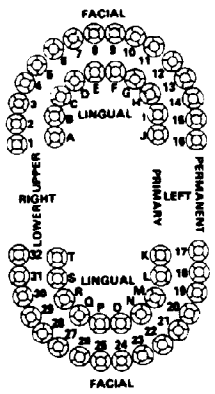
35. Is treatment for orthodontics?

If service already commenced enter:

Date appliances placed

Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee
		Complete upper denture	MM DD YY	05110	xxx xx
		Amalgam	MM DD YY	02160	xx xx
		Open tooth for drainage	MM DD YY	W7118	xx xx

For administrative use only: E

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

› IM Authorized Signed (Treating Dentist) License Number MMDDYY Date

40. Address where treatment was performed: IM Performing Provider 87654321 City State Zip

41. Total Fee Charged xxx xx

42. Payment by other plan xx xx

Max. Allowable

Deductible

Carrier %

Carrier pays

Patient pays

J510 (Same as ADA Dental Claim Form - J504, J511, J512)

Appendix 27
American Dental Association Claim Form Completion Instructions

To avoid unnecessary denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is specified.

Wisconsin Medicaid recipients receive a Medicaid identification card upon initial enrollment into Wisconsin Medicaid and at the beginning of each month thereafter. This card must always be presented prior to rendering the service. Please use the information exactly as it appears on the Medicaid identification card to complete the information in the patient information section.

Element 1 - Provider ID #
Enter the billing provider's eight-digit provider number. (*Note*: A group billing provider number must be entered in this element if a performing provider number is entered in element 40.)

Element 2 - EPSDT/Prior authorization #/Patient ID#
HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

EPSDT: If the services were performed as a result of a HealthCheck/EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved prior authorization form. Do not attach a copy of the PA form to the claim. Services authorized under different PA numbers must be billed on separate claim forms.

Patient ID#: Enter the recipient's 10-digit Medicaid identification number from the Medicaid identification card.

Element 3 - Carrier name and address (not required)

Element 4 - Patient name
Enter the recipient's first name, middle initial, and last name as they appear on the current Medicaid identification card.

Element 5 - Relationship to employee (not required)

Element 6 - Sex
Check "M" for male or "F" for female.

Element 7 - Patient birthdate
Enter the recipient's date of birth in MMDDYY format (e.g., June 18, 1964, would be 061864) as it appears on the Medicaid identification card.

Element 8 - If full time student (optional)
You may enter the patient's internal office account number here. This number will appear on the fiscal agent Remittance and Status report (maximum of 14 characters).

Element 9 - Employee/subscriber name and mailing address (not required)

Element 10 - Employee/subscriber dental plan ID number (not required)

Element 11 - Employee/subscriber birthdate (not required)

Element 12 - Employer (company) name and address (not required)

Element 13 - Group number (not required)

Element 14 - If patient covered by another dental plan... (not required)

Element 15a - Name and address of carriers
Medicare must be billed for covered services before billing Wisconsin Medicaid if Medicare covers the service. When the recipient's Medicaid identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes must be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

Dental Only third party coverage (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid. This new billing policy applies only to dentists using the ADA claim form. Dental Only third party insurance will be indicated in the "Other Coverage" space on the recipient's Medicaid identification card as "DEN".

If a recipient has only Dental Only third party insurance, then DEN will appear on the Medicaid identification card as a separate code. If a recipient has other third party insurance in addition to Dental Only third party insurance, then multiple insurance indicators will appear on the Medicaid identification card: for example, BLU, DEN.

When the dental provider has not billed other insurance because the "Other Coverage" of the recipient's Medicaid identification is blank, this element must be left blank.

When the "Other Coverage" space shows HPP, BLU, WPS, CHA, OTH, HMO, or HPP, but *not DEN*, and the service is not dental surgery, this element must be left blank.

When the "Other Coverage" space of the recipient's Medicaid identification card indicates BLU, WPS, CHA, or OTH, *but not DEN*, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in element 15a. The description of the code is not required, nor is policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	Yes, card indicates other coverage, but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate. - Service in question is known to be noncovered. - Insurance failed to respond to initial and follow-up claim. - Benefits not assignable or cannot get an assignment.

When "Other Coverage" space of the recipient's Medicaid identification card indicates HMO or HMP, *but not DEN*, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in element 15a. The description of the code is not required, nor is policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 15b - Group no.(s) (not required)

Element 16 - Name and address of other employer(s) (not required)

Element 17a - Employee/subscriber name (not required)

Element 17b - Employee/subscriber dental plan ID number (not required)

Element 17c - Employee/subscriber birthdate (not required)

Element 18 - Relationship to patient (not required)

Element 19 - Patient signature block (not required)

Element 20 - Employee/subscriber block (not required)

Element 21, 22, and 23 - Name and address of billing dentist or dental entity
Enter the billing provider's complete address.

Element 24 - Dentist's Social Security number or tax identification number (not required)

Element 25 - Dentist license number (not required)

Element 26 - Dentist phone no. (not required)

Element 27 - First visit date (not required)

Element 28 - Place of treatment
Enter the appropriate HCFA place of service code in the "Other" column. If the place of service entered is "Other," describe the place of service. Enter only one place of service code.

Code	Description
1	Inpatient hospital
2	Outpatient hospital
3	Office
4*	Home
7	Nursing home
8	Skilled nursing facility
0**	Other
B	Ambulatory surgical center

* = Enter the reason for performing dental service in the recipient's residence in element 38.
** = Enter the place of service's location and the reason for performing the dental procedure in an outside location in element 38.

Element 29 - Radiographs or models enclosed? (not required)

Element 30 - Is treatment result of occupational illness or injury?
Specify if the dental services were the result of an occupational illness, injury, or accident. Check no or yes. If yes is indicated for any one of the conditions, write a brief explanation in the space provided.

Element 31 - Is treatment result of auto accident? (required if applicable)

Element 32 - Other accident? (required if applicable)

Element 33 - If prosthesis, is this initial placement? (not required)

Element 34 - Date of prior placement (not required)

Element 35 - Is treatment for orthodontics? (not required)

Element 36 - Specify missing teeth with an "X" (optional)
Identify any missing or extracted teeth with an X" on the tooth chart.

Element 37 - Examination and treatment plan

Tooth # or letter: If the procedure applies to only one tooth, the tooth modifier (i.e., tooth number or tooth letter) is entered in element 37. If the procedure applies to only one denture repair, the modifier (i.e., UU or LL) is entered in element 37. Refer to Section IV-E of this handbook for more modifier information.

Surface: Enter the tooth surface(s) restored for each restoration.

Description of service: Write a brief description of each procedure. An exact quantity is entered in this element for procedure codes 00230, 00240, 00260, 04211, and 09220 only. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.)

Date service performed: Enter the date of service in MMDDYY format (e.g., July 1, 1995, would be 070195) for each detail.

Procedure number: Enter the procedure code for the dental service provided. Refer to Appendices 9 through 19 of this handbook for a complete list of covered codes.

Fee: Enter the total charge for each detail.

For administrative use only: Enter an "E" in this element if the service is an emergency. Wisconsin Medicaid's claims processing system only accepts the letter "E," with no other letters, as an indication of an emergency.

Element 38 - Remarks for unusual services (not required)

Element 39 - Dentist's signature block

The provider, or an authorized representative, must sign in element 39. Also enter the month, day, and year that the form is signed.

Note: This may be a computer-printed name and date or a signature stamp.

Element 40 - Address where treatment was performed

If the dentist who performed the service is different than the billing provider, enter the performing provider's name and eight-digit provider number.

Element 41 - Total fee charged

Enter the total of all detail charges.

Element 42 - Payment by other plan

Enter the total dollar amount paid by any other insurance. Do not include the copayment amount.

If other insurance paid on only some services, those partially paid services should be billed on a separate claim from the unpaid services. This allows the fiscal agent to appropriately credit the payments.

Patient pays: Enter the spenddown amount, when applicable. Write "Spenddown" to the left of the *patient pays* box. Refer to Part A, the all-provider handbook, for information on recipient spenddown.

Appendix 28
HCFA 1500 Claim Form Example

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) P | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (xxx) xxx-xxxx

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 802.35 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		1	G	07230	17	1	xx xx	1.0		E		
2 MM DD YY		1	G	07220	16	1	xx xx	1.0		E		
3 MM DD YY		1	G	21230		1	xx xx	1.0		E		
4 MM DD YY		1	G	21346	80	1	xx xx	1.0				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234ABCD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ xx xx

29. AMOUNT PAID $

30. BALANCE DUE $ xx xx

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Authorized

SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I. M. Billing Provider
1 W. Williams
Anytown, WI 55555

PIN# GRP# 76543210

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix 29
HCFA 1500 Claim Form Instructions For Dental Services

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

If a dentist is providing both CPT and ADA dental procedures, both may be billed on the HCFA 1500 claim form. The only exception to this is that restorative services requiring tooth number and surface information must be billed on the dental claim form.

Wisconsin Medicaid recipients receive a Medicaid identification card upon initial enrollment into Wisconsin Medicaid and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medicaid identification card to complete the patient and insured information.

Element 1 - Program block/claim sort indicator
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. number
Enter the recipient's 10-digit Medicaid identification number as found on the current Medicaid identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's name
Enter the recipient's last name, first name, and middle initial as it appears on the current Medicaid identification card.

Element 3 - Patient's birth date, patient's sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medicaid identification card. Specify if male or female with an "X."

Element 4 - Insured's name (not required)

Element 5 - Patient's address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient relationship to insured (not required)

Element 7 - Insured's address (not required)

Element 8 - Patient status (not required)

Element 9 - Other insured's name
Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing according to Appendix 18a of Part A, the all-provider handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank, the service does not require third party billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's Medicaid identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

- Recipient denies coverage or will not cooperate.
- The provider knows the service in question is noncovered by the carrier.
- Insurance failed to respond to initial and follow-up claim.
- Benefits not assignable or cannot get an assignment.
- When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation amount.

Element 10 - Is patient's condition related to (not required)

Element 11 - Insured's policy, group, or FECA number

The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to Wisconsin Medicaid. When the recipient's Medicaid identification card indicates Medicare coverage, but Medicare does not pay, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.

M-6 Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medicaid identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

Elements 12 and 13 - Authorized person's signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of current illness, injury, or pregnancy (not required)

Element 15 - If patient has had same or similar illness (not required)

Element 16 - Dates patient unable to work in current occupation (not required)

Element 17 - Name of referring physician or other source (not required)

Element 17a - I.D. number of referring physician (not required)

Element 18 - Hospitalization dates related to current services (not required)

Element 19 - Reserved for local use
If an unlisted procedure code is billed, providers must describe the procedure. If element 19 does not provide sufficient space for the procedure description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19. This element may be used for narratives required to exceed limitations.

Element 20 - Outside lab (not required)

Element 21 - Diagnosis or nature of illness or injury
The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid resubmission (not required)

Element 23 - Prior authorization
Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers.

Element 24a - Date(s) of service

Enter the month, day, and year for each procedure when billing for one date of service, enter the date in MM/DD/YY format in the "FROM" field. It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of service

Enter the appropriate Wisconsin Medicaid *single-digit* place of service code for each service. Refer to Appendix 30 of this handbook for Wisconsin Medicaid allowable place of service codes.

Element 24c - Type of service code

Enter the type of service "G."

Element 24d - Procedures, services, or supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. The only modifier valid for these CPT procedure codes is "80." If using ADA codes that require tooth modifiers, the tooth numbers or letters must be indicated.

Element 24e - Diagnosis code

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line item.

Element 24g - Days or units

Enter the total number of services billed for each line item.

Element 24h - EPSDT/family planning

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Enter an "H" for each procedure that was performed as a result of a HealthCheck exam. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG

Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for local use
Enter the eight-digit, Medicaid provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and, under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this element may cause claim denial.

Element 25 - Federal tax ID number (not required)

Element 26 - Patient's account number
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total charge
Enter the total charges for this claim.

Element 29 - Amount paid
Enter the amount paid by other insurance. If other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of physician or supplier
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and address of facility where services rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medicaid provider number.

Element 33 - Physician's, supplier's billing name, address, zip code, and phone #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.